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SENATE BILL 2921
By Graves

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, Part 1, relative to the timely reimbursement of health insurance claims.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-109(a), is amended by deleting subsection (1)(A) in its entirety and by substituting instead the following:

(1)

(A) "Clean Claim" means a claim received by the health insurance entity by a provider that contains substantially all the required data elements necessary for accurate adjudication.

SECTION 2. Tennessee Code Annotated, Section 56-7-109(b), is amended by deleting the subsection in its entirety and substituting instead the following language:

(1) Prompt Payment Standards: Not later than thirty (30) calendar days after the date that a health insurance entity actually receives a claim submitted on paper from a provider, the health insurance entity shall:

(A) If the claim is clean, pay the total covered amount of the claim; or

(B) Pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid.

The health insurance entity shall include in the notification the need for any attachments desired in good faith for clarification of a clean claim. The provider must receive this notice not later than the tenth (10th) day after the date the health insurance entity receives the claim. To be valid, the written notice requesting the attachment shall describe with specificity the clinical information requested, provide a detailed description of the reasons why the health insurance entity is requesting the information, and pertain only to the information that the health insurance entity can demonstrate is not only within the scope of the claim but also specific to the claim in question. Upon receiving a valid request, the provider shall have ten (10) days to provide the attachment without tolling the thirty (30) day payment period required by this section.

(2) Not later than twenty-one (21) calendar days after the date that a health insurance entity actually receives a claim by electronic submission from a provider, the health insurance entity shall:

(A) Within forty-eight (48) hours of receiving an original or corrected claim submitted electronically, the health insurance entity shall acknowledge the date of receipt of the claim by an electronic transmission to the provider; and

(B) If the claim is clean, pay the total covered amount of the claim; or

(C) Pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid. The health insurance entity shall include in the notification the need for any attachments desired in good faith for clarification of a clean claim. The provider must receive this notice not later than the tenth (10th) day after the date the health insurance entity receives the claim. To be valid, the written notice requesting the attachment shall describe with specificity the clinical information requested, provide a detailed description of the reasons why the health insurance

entity is requesting the information, and pertain only to the information that the health insurance entity can demonstrate is not only within the scope of the claim but also specific to the claim in question. Upon receiving a valid request, the provider shall have ten (10) days to provide the attachment without tolling the twenty-one (21) day payment period required by this section.

(3) If a health insurance entity requires a provider to submit attachments to the claim containing additional information before the claim will be paid, the health insurance entity shall identify the specific routinely required information in its provider manual or other documents that sets forth the procedure for filing claims with the health insurance entity. The health insurance entity shall provide sixty (60) days advance written notice of modifications to the provider manual that materially change the type of content of the attachments to be submitted.

(4) A request for additional attachments or corrections to the claim submission may only be made one time by the health insurance entity.

(5) No paper claim may be denied upon resubmission for lack of substantiating documentation or information that has been previously provided by the health care provider.

(6) Any health insurance entity that does not comply with subdivision (b)(1) or (b)(2) shall pay interest on the amount of the claim that remains unpaid according to the following schedule:

(A) For claims that are paid between thirty-one (31) and sixty (60) days from the date that the claim was received by the health insurance entity, interest at a rate of twelve percent (12%) per annum shall accrue from the date payment was due under Section (b)(1) or (b)(2);

(B) For claims that are paid between sixty-one (61) and ninety (90) days from the date that the claim was received by the health insurance entity, interest

at a rate of eighteen (18%) per annum shall accrue from the date payment was due under Section (b)(1) or (b)(2); and

(C) For claims that are paid more than ninety (90) days from the date that the claim was received by the health insurance entity, interest at a rate of twenty-one (21%) per annum shall accrue from the date payment was due under Section (b)(1) or (b)(2).

(7) Any interest accrued in accordance with Section (b)(6) shall be automatically paid to the provider within sixty (60) calendar days and shall identify the claim(s) to which it applies.

(8) The commissioner of commerce and insurance may not by rule add or create any additional requirements on the provider than those established by this section.

(9) The provisions of this section may not be waived or nullified by contract.

SECTION 3. Tennessee Code Annotated, Section 56-7-109(d), is amended by deleting the section in its entirety and substituting instead the following language:

(d) Not later than January 1, 2003, the commissioner of commerce and insurance in consultation with the commissioner of health shall develop and promulgate by rule a uniform claims process, which contains standardized instructions for completing the form and creates standardized responses to questions and other information required on the form, for providers to use in the submission of claims for reimbursement. Provider representatives must be consulted during the promulgation of these rules.

SECTION 4. This act shall take effect July 1, 2002, the public welfare requiring it.